STATE OF NORTH DAKOTA

BOARD OF MEDICAL EXAMINERS

IN THE MATTER OF:	)	
	)	**RECOMMENDED**
North Dakota State Board of Medical	)	**FINDINGS OF FACT,**
Examiners - Investigative Panel B,	)	**CONCLUSIONS OF LAW,**
	)	**AND ORDER, AND**
Complainant,	)	**PROTECTIVE ORDER**
vs.	)	
	)	**OAH File No. 20040408**
Mario Albertucci, M.D.	)	
	)	
Respondent.	)	
	)	

. . . . . .

On July 20, 2004, a Complaint was filed with the North Dakota Board of Medical Examiners ("Board") by John M. Olson, special assistant attorney general, counsel for the Board's Investigative Panel B, requesting revocation of the license to practice medicine in North Dakota of Mario Albertucci, M.D. ("Albertucci"). The Complaint cites as grounds for disciplinary administrative action by the Board violations of N.D.C.C. § 43-17-31, alleging that Albertucci engaged in a continued pattern of inappropriate care within the meaning of N.D.C.C. § 43-17-31(21), regarding the medical care he gave to three patients. (As in the Complaint, the three patients will be hereinafter referred to as Patient 1, Patient 2, and Patient 3.)

On November 9, 2004, the Board requested the designation of an administrative law judge (ALJ) from the Office of Administrative Hearings to preside as its hearing officer, *i.e.*, to conduct a hearing and to issue recommended findings of fact and conclusions of law, as well as a recommended order to the Board in regard to the Complaint. On November 10, 2004, the undersigned ALJ was designated.

On November 15, 2004, the ALJ issued a Notice of Hearing. The hearing was scheduled as an in-person hearing for December 21, 2004, at the Office of Administrative Hearings, Bismarck, North Dakota. After receiving the notice, Albertucci inquired about participating in the hearing form his home in Rome, Italy. The Board had no objection to him doing so.

The hearing was held as scheduled on December 21. Albertucci appeared via telephone from Italy. He represented himself. Mr. Olson represented Investigative Panel B. Mr. Olson called three witnesses, Albertucci, the Board's Executive Secretary, Rolf Sletten, and an expert witness, Michael D. Traynor, M.D., a Fargo surgeon. Mr. Olson offered one exhibit (exhibit 1, a large black binder), which includes the *curriculum vitae* of Dr. Traynor (Part A); Dr. Traynor's evaluation of five cases for the Board under cover of a May 8, 2004, letter (which includes evaluation of the care given to Patient 1, Patient 2, and Patient 3 (Part B); the medical records of Patient 1 (Part C); the medical records of Patient 2 (Part D); the medical records of Patient 3 (Part E); and a December 23, 2002, letter from Dr. Sean Russell to Medcenter One Health Systems stating the Surgery Quality Subcommittee recommendations regarding Albertucci (Part F). Exhibit 1 was admitted. Albertucci offered no exhibits. He offered no expert testimony. He offered only his own testimony in regard to the care he provided these three patients and he questioned the Board's expert witness, Dr. Traynor.

Prior to presenting evidence, Mr. Olson moved for the issuance of a protective order to protect the confidentiality of patient names, medical information and records, and other patient identifying information. Because no member of the public or media attended the hearing, patient names and other patient identifying information were given at the hearing. Albertucci did not object to the issuance of a protective order.

At the close of the hearing, the ALJ heard oral argument from Albertucci and Mr. Olson.

PROTECTIVE ORDER

A protective order is issued under N.D.C.C. §§ 23-34-02, 28-32-33, 43-17-07.1, 43-17.1-05.1, 43-17.1-06, 43-17.1-08, and N. D. R. Ev. 503 to protect the confidentiality and identity of patients during the course of the hearing and related proceedings.

Accordingly, because the Complaint involves allegations regarding three patients, referred to in the Complaint as Patient 1, Patient 2, and Patient 3, it is ORDERED that public disclosure of the name, identity, patient information, and medical records of Patient 1, Patient 2, and Patient 3, as well as any other evidence introduced during the course of these proceedings that may identify these three patients, is prohibited. This prohibition on public disclosure applies to any stage of this administrative proceeding. The parties and counsel shall take necessary steps during post-hearing proceedings to keep confidential all records and other documents referring to these three patients, including the hearing tapes, as well as any reference to the names of these three patients. Any portion of the record of this matter, including all of exhibit 1 and the two hearing tapes are protected.

Additionally, all records and other documents in this administrative proceeding referring to these three patients will be considered confidential, are closed and sealed subject to specific request made to the Board's hearing officer or the Board for public disclosure, and approval by the Board's hearing officer or the Board for public disclosure of all or any part of the sealed record.

Subject to the above constraints, the parties, counsel, the Board's hearing officer, and the Board shall not otherwise be constrained from commenting fully upon the testimony presented,

any material contained in the documents, or from using any documents or testimony for a lawful purpose.

FINDINGS OF FACT

Based on the evidence presented at the hearing and the oral argument of the parties, the ALJ makes the following recommended findings of fact.

1. At the time of the allegations of violation of N.D.C.C. § 43-17-31(21), with regard to Patient1, Patient 2, and Patient 3, in the Complaint, Albertucci was licensed to practice medicine in North Dakota under license number 8360.

2. Albertucci was issued a temporary license by the Board on January 10, 2000, and was issued a permanent license by the Board on March 24, 2000.

3. Albertucci's license to practice medicine in North Dakota expired December 31, 2003, and it has not been renewed, but, barring disciplinary action, his license could be automatically renewed by him upon registration and payment of a fee during the period of a three year window beginning December 31, 2003.

4. While in North Dakota, Albertucci specialized in general and thoracic surgery at Medcenter One Health Systems in Bismarck. Albertucci is board certified in general surgery and thoracic surgery.

5. Albertucci admitted treating Patient 1, Patient 2, and Patient 3 as alleged in the Complaint, at the times indicated in the medical records of these patients.

6. Prior to the hearing, Dr. Traynor reviewed the medical records regarding Patient 1, Patient 2, and Patient 3, as well as two other of Albertucci's patients. He issued to the Board his evaluation of Albertucci's care given these five patients in a report attached to his May 8, 2004, letter to the Board. Exhibit 1, Part B.

7. Generally, in his May 8, 2004, evaluation report, Dr. Traynor found that Albertucci gave inappropriate care to Patient 1, Patient 2, and Patient 3, as alleged in the Complaint, but not to the other two patients. *Id.*

8. At the hearing, after listening to Albertucci testify, Dr. Traynor explained the findings and conclusions of his report on the three patients in question and Dr. Traynor's general conclusions were not changed from those made in his evaluation report as a result of any of Albertucci's testimony. Further, after cross examination of Dr. Traynor by Albertucci and further testimony given by Albertucci, Dr. Traynor did not change his general conclusions about the care Albertucci gave to the three patients in question. In fact, in some respects, Dr. Traynor was even more concerned about the care and treatment Albertucci provided to these three patients after listening to Albertucci's testimony. He said he found some of Albertucci's testimony to be inaccurate. He said that Albertucci's care and treatment of Patient 2 was "very disconcerting to me." Dr. Traynor continued to maintain that Albertucci provided inappropriate care with regard to each of the three patients.

9. Specifically, Patient 1 was admitted to Medcenter One on December 12, 2002, for a nonfunctioning dialysis catheter that Albertucci attempted to replace over a guide wire. Albertucci lost the guide wire into the central circulation after cutting it in its mid portion. He attempted to retrieve the guide wire by doing an aggressive cutdown with division of the clavicle. His final approach to having the guide wire removed was by a cardiologist or an interventional radiologist through the right femoral vein. Dr. Traynor opined that Albertucci used poor judgment in dividing these catheters without having them properly secured, and in dividing the clavicle before attempting percutaneous removal, which was the method that was

eventually successful. Patient 1 was in surgery with Albertucci for about four hours. Exhibit 1, at B; *see* exhibit 1 at C.

10. Specifically, Patient 2 was a resident of the SCCI Hospital and was admitted, discharged, and readmitted to Medcenter One over the course of October 5 - 15, 2001, at which time Patient 2 expired. On October 5, 2001, Albertucci removed an infected left sided dialysis catheter without apparent complications, which appears to be appropriate. Patient 2 was readmitted to Medcenter One for surgery, for placement of a new dialysis catheter on October 8, 2001, which was performed by Albertucci through a left internal jugular venous approach. The operative report revealed no apparent problems and Albertucci believed that the catheter was in an appropriate position under fluoroscopy. However, the chest x-ray performed that day showed that Patient 2 had opacification of the left thorax on the same day as the surgery, October 8, 2001. Patient 2 was discharged without any comment regarding the post-procedure chest x-ray which showed that the catheter was in an aberrant position. Patient 2 was sent back to SCCI Hospital. The dialysis nurses and Patient 2's nephrologist noted that Patient 2's catheter was not working well for dialysis and they believed that the tip was aberrantly placed. Patient 2 was transported back to Medcenter One and in the emergency room Albertucci removed the dialysis catheter and the patient had a cardiac arrest from apparent exsanguinations into the left chest. He had a chest tube placed that had 3000 mL of blood. His chest x-ray on October 10, 2001, showed evidence of a tension hemothorax. Patient 2 had a full arrest, never recovered and had brain death. Life support systems for Patient 2 were withdrawn on October 15, 2001.
Dr. Traynor was concerned that Albertucci did not review his post-procedure chest x-ray, which clearly indicated there was opacification of the left chest, which would most likely indicate bleeding from a lacerated subclavian or other intrathoracic arterial structure. Dr. Traynor

believes the fact that when Albertucci pulled the catheter, Patient 2 exsanguinated, is further confirmation of his concerns. Dr. Traynor believes Albertucci exhibited neglect of the patient, poor clinical judgment, and poor follow-up in this case. Exhibit 1, at B; *see* exhibit 1, at C.

11. Specifically, Patient 3 was also an Albertucci patient at Medcenter One, on November 8, 2002. Patient 3 had an indwelling right internal jugular catheter that was not functioning well and a preoperative venogram showed narrowing of the distal subclavian vein. Albertucci believed that a catheter with a longer tip could be placed past this narrowed vein. The venorgram obviously showed some narrowing or abnormality of the superior vena cava and Dr. Traynor believes that Albertucci tried to force a catheter through an obstructed area. Dr. Traynor said Albertucci used "skewed judgment" in trying to place a catheter with a longer tip past this narrowed vein and showed bad "surgical judgment" in trying to force a catheter through an obstructed area. Patient 3 was subsequently taken to the operating room. Catheters were replaced over guide wires. Albertucci reported that the post procedure chest x-ray showed no pneumothorax, however, later on dialysis that day, Patient 3 arrested, and he later died. The only chest x-ray report in the medical record shows a large right pneumothorax and questionable left pleural effusion, which may have indicated bleeding into the left chest. Dr. Traynor said it was evident that either the chest x-ray was not reviewed appropriately or a post procedure chest x-ray was not done before dialysis was initiated. Dr. Traynor said further that his review indicates that Patient 3 likely succumbed from a tension pneumothorax caused by manipulation of the right pleural cavity. Exhibit 1, at B; *see* exhibit 1, at E.

12. Albertucci did make some admissions at the hearing. He admitted to failure to document some of the procedures he used and admitted to "missing the pneumothorax on the chest x-ray for Patient 3. However, Albertucci faulted the radiologist for not timely reading the

chest x-ray and communicating information about the pneumothorax to him. After Dr. Traynor said that the blame in this case could not and should not be placed on the radiologist, Albertucci admitted his fault for not taking another chest x-ray. Although Albertucci first claimed that he did not force the catheter through an obstructed area for Patient 3, later in his testimony Albertucci admitted that Patient 3's pneumothorax was likely caused by the procedure he undertook.

13. Albertucci did deny some of the allegations of the Complaint and had explanations for most of the concerns expressed by Dr. Traynor. However, Albertucci's assertions and explanations lack the backing of any expert testimony on his behalf, and the hearing officer believes the findings and conclusions of Dr. Traynor are convincing.

14. In his closing argument at the hearing, Albertucci noted the complexity of the three cases in question and said that he used his knowledge and best judgment in caring for and treating these three patients.

15. On December 23, 2002, the chairperson of the Medcenter One Surgery Quality Subcommittee wrote to Albertucci at the Medcenter One Health Systems, Q & R Clinic, after the Surgery Service Line Quality Subcommittee, as part of Type II Case Review, had reviewed certain referenced cases. The subcommittee approved continuing

> [v]oluntary suspension of [Albertucci's] privileges for central catheter placement of dialysis catheters … until physician provides evidence of education by an academic center or manufacturer of dialysis devices and is proctored on 10 cases. In addition the individual will attend anger management counseling either here or at another facility of the physician's choice. In addition the Administrative Surgeon on call will, if there is any dispute about the placement or removal of these devices, immediately suspend clinical privileges for this procedure.

Exhibit 1, at F.

CONCLUSIONS OF LAW

Based on the findings of fact, the ALJ makes the following conclusions of law.

1. At the time of him providing care to Patient 1, Patient 2, and Patient 3, Albertucci was licensed to practice medicine in North Dakota under license no. 8360, and was, therefore, subject to the jurisdiction of the Board. His actions and activities as a licensee in North Dakota at that time make him subject to regulation by the Board under the provisions of N.D.C.C. chapters 43-17 and 43-17.1.

2. Albertucci is not currently licensed in North Dakota but is still subject to disciplinary action imposed by the Board under N.D.C.C. chapter 43-17 because of his actions and activities when he did have a current license, and because, barring disciplinary action, he may still automatically renew his expired license.

3. The greater weight of the evidence shows that while engaged in the practice of medicine in North Dakota, as pertains to the allegations of the Complaint, Albertucci engaged in a continued pattern of inappropriate care within the meaning of N.D.C.C. § 43-17-31(21), with regard to three patients to whom he provided care, Patient 1, Patient 2, and Patient 3.

4. Violation of N.D.C.C. § 43-17-31(21) is a ground for the Board taking disciplinary action against Albertucci. The Board has authority under the provisions of N.D.C.C. § 43-17-30.1 to take various types of disciplinary action against a licensed physician for proven violations N.D.C.C. § 43-17-31, including revoking a license.

5. The Board has authority under N.D.C.C. § 43-17-31.1, in a disciplinary proceeding in which disciplinary action is imposed against a physician, to also direct the physician to pay to the Board a sum not to exceed the reasonable and actual costs, including

reasonable attorney's fees incurred by the Board and its investigative panels in the investigation and prosecution of the case.

RECOMMENDED ORDER

The greater weight of the evidence shows that Albertucci violated the provisions of N.D.C.C § 43-17-31(21), essentially as alleged in the Complaint. For such proven violations of N.D.C.C. § 43-17-31, the ALJ recommends that the Board **revoke** Albertucci's license to practice medicine in North Dakota. Further, because of the proven violations of N.D.C.C. § 43-17-31, the ALJ recommends that the Board direct Albertucci to pay to the Board a sum not to exceed the reasonable and actual costs, including attorney's fees, incurred by the Board and its investigative panel in the investigation and prosecution of his case.

Dated at Bismarck, North Dakota, this 30th day of December, 2004.

State of North Dakota
Board of Medical Examiners

By: _____
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